Dr Joel W Lovell

Patient Health History New Patient

Patient Name: Birth Date: Date Created:

What is your PREFERRED name? Comment

Who May We THANK for REFERRING you to our office? Comment

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS?	◯ Yes ◯ No	If yes
Are you under a PHYSICIAN'S CARE now?	◯ Yes ◯ No	If yes
Any special concerns?	◯ Yes ◯ No	If yes
Are you currently taking any MEDICATIONS?	◯ Yes ◯ No	If yes
Have you ever used a BISPHOSPHONATE MEDICATION? Fosamax,Actonal, Atelvia, Didonel _Boniva	◯ Yes ◯ No	If yes
Are you PREGNANT?	◯ Yes ◯ No	
Do you use CIGARS/CIGARETTES, PIPE, CHEWING TOBACCO? (circle)	◯ Yes ◯ No	If yes
If you have had joint replacement, please list which joint and when it was done.	◯ Yes ◯ No	If yes

PLEASE CHECK YES/NO FOR ANY OF THE FOLLOWING YOU HAVE HAD OR PRESENTLY HAVE:

AIDS/HIV Pos.	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Psychiatric care	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Food allergies	◯ Yes ◯ No	Rapid Weight gain/loss	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Radiation treatment	◯ Yes ◯ No
Arthritis (Rheumatism)	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Artificial heart valves	◯ Yes ◯ No	Heart murmur	◯ Yes ◯ No	Rheumatic/scarlet fever	◯ Yes ◯ No
Artificial joints	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Hemophilla(abnormal bleeding)	◯ Yes ◯ No	Shortness of breath	◯ Yes ◯ No
Atopic (Allergy Prone)	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Skin rash	◯ Yes ◯ No
Back problems	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Sleep apnea	◯ Yes ◯ No
Blood disease	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Jaw pain	◯ Yes ◯ No	Swelling feet or ankles	◯ Yes ◯ No
Chemical dependency	◯ Yes ◯ No	Kidney disease or malfunction	◯ Yes ◯ No	Thyroid disease/malfunction	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Liver disease	◯ Yes ◯ No	Tobacco habit	◯ Yes ◯ No
Circulatory problems	◯ Yes ◯ No	Material allergies-metal,chemicals	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cortisone treatments	◯ Yes ◯ No	Mitral valve prolapse	◯ Yes ◯ No	Ulcer/Colitis	◯ Yes ◯ No
Cough persistent	◯ Yes ◯ No	Nervous problems	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Cough up blood	◯ Yes ◯ No	Pacemaker/heart surgery	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No

ALLERGIES TO MATERIALS/MEDS

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

☐ Aspirin	☐ Local Anesthetic	☐ Erythomycin/Clindamycin	☐ Latex (balloons, gloves, etc.)
☐ Penicillin	☐ Codeine	☐ Sulfa	☐ Zithromax

Are you aware of being allergic to any other medications or substances? If yes, please list:	◯ Yes ◯ No	If yes	
Is there any other Medical or Dental information that you feel we should know about?	◯ Yes ◯ No	If yes	
FAMILY PHYSICIAN	◯ Yes ◯ No	If yes	
Physician PHONE#	◯ Yes ◯ No	If yes	

DENTAL HISTORY

HOW LONG SINCE you have seen a dentist?			
Last COMPLETE dental exam, Date:_____			
Last FULL MOUTH X-RAYS, DATE:_____			
Are you having PROBLEMS now?	◯ Yes ◯ No	If yes	
Name of previous DENTIST and address:		Comment	

Please answer YES/NO for following questions:

Is Your present dental health POOR?	◯ Yes ◯ No
Do you wear DENTURES, full or partial?	◯ Yes ◯ No
Are you UNHAPPY with your dentures?	◯ Yes ◯ No
Do you want information on PERMANENT REPLACEMENTS?	◯ Yes ◯ No
Are you APPREHENSIVE about dental treatment?	◯ Yes ◯ No
Have you had any PERIODONTAL (Gum) treatments?	◯ Yes ◯ No
Do your gums BLEED,feel TENDER or IRRITATED?	◯ Yes ◯ No
Are your teeth SENSITIVE to hot, cold, sweets?	◯ Yes ◯ No
Are you UNHAPPY with APPEARANCE of your teeth?	◯ Yes ◯ No
Do you GRIND or CLENCH YOUR TEETH?	◯ Yes ◯ No
Do you have HEADACHES, EARACHES, or NECK pains?	◯ Yes ◯ No
Have you worn BRACES on your teeth?	◯ Yes ◯ No
Do you have DISCOLORED teeth that bother you?	◯ Yes ◯ No
Would you like you smile to LOOK BETTER?	◯ Yes ◯ No
Do you REGULARLY use DENTAL FLOSS?	◯ Yes ◯ No

Signature of Patient, Parent or Guardian:

X

Date:_____